RN III (Care Manager)
Ambulatory Care Clinics

The Care Manager is a Registered Nurse III assigned to Harbor-UCLA Medical Center, Patient-Centered Medical Home (PCMH) within Ambulatory Care Services. The Care Manager is a Registered Nurse who collaborates with the PCMH Team (provider, Caregiver, LVN, CMA and clerical staff) to lead and coordinate patient empanelment. The Care Manager is primarily responsible for providing nursing care to high-risk patients and the coordination of clinical panel management (non-visit driven, and population level care). This position reports to the Supervising Clinic Nurse or Nurse Manager.

RESPONSIBILITIES:

- Managing patient empaneled of the Medical Homes. Follow-up Emergency Room (ER)/UCC visits and hospital admittances in order to arrange appropriate follow-up with the empaneled provider/team within 7 days of discharge, or sooner if the clinical situation warrants it.
- Shares clinical information with admitted hospitals and emergency departments. Exchanges patient information with the hospital during a patient's hospitalization. Assembles cases of high-risk patients that are eligible for care management. Evaluates and performs assessment on high-risk patients that are overdue for disease management interventions or diagnostic tests; make possible referral to disease management programs, and other health education assistance.
- Uses available clinical protocols to manage high-risk chronic disease patients within the Care Manager's scope of practice. Performs one-on-one in-person, telephone, or small group sessions for high-risk patients and their family members for patient/family education or carrying out the care plan as necessary and at the direction of the PCMH provider. Provides authorizations for home health, DME, ABT therapy, formula, IHSS, etc. for all clinics.
- Contacts internal and external care managers as necessary to facilitate transitions.
- Follow-up and tracks high-risk or urgent e-consults referrals. Documents outreach, care plan and program referrals in the medical record. Identifies, addresses, and resolves barriers that may be affecting patient care.
- Generates panel reports and implement performance activities to improve care for the empaneled patient population in collaboration with the Medical Director. Participates in the assigned medical home team huddles as needed or requested by provider. Participates in multi-disciplinary team meetings. Participates in QI monitoring and reporting performance improvement activities.
- Develops and builds population of high risk patient populations; develops plans/strategies to assist high risk patient populations. Assists in care coordination with subspecialists and/or specialty

DESIRED QUALIFICATIONS:

- Must have three years of clinical nursing experience within the last 5 years
- Experience conducting complex investigations and must have good written and verbal communication skills
- Ability to manage multiple assignments simultaneously
- Strong organizational, team building, critical thinking and conflict resolution skills

Candidates must currently be a permanent County of Los Angeles employee who hold the payroll title of Registered Nurse III to be considered for a lateral transfer or a reachable candidate on the DHS certification list to be considered for a promotion or as a new hire. Resumes will be accepted until the needs of the department are met. The highest reviewed and qualified candidates will be contacted for interviews. Interested candidates, please submit a cover letter, resume, 2 years performance evaluations and last two years of time records to:

Richard Guitche, RN (rguitche@dhs.lacounty.gov)

Alan Noel, RN (anoel@dhs.lacounty.gov)

Nursing Recruitment and Retention Center- Building D3.5
1000 West Carson Street, Torrance, CA 90509
Phone: (310) 222-2512, Fax: (3107870065)

"This is not a civil service examination"